

EINHORN (M.)

ENTEROPTOSIS.

BY

MAX EINHORN, M.D.,
OF NEW YORK.

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ENTEROPTOSIS.¹

BY MAX EINHORN, M.D.,
OF NEW YORK.

ENTEROPTOSIS designates a condition in which the suspensory ligaments of some of the abdominal viscera are relaxed, causing a more or less pronounced descent of these organs.

The disease begins with a prolapse of the intestines, particularly of the right part of the colon transversum, due to a relaxation of the weak ligamentum colico-hepaticum. The colon ascendens and colon transversum, losing their ligamentous suspension, sink down, and so the colon transversum, instead of running straight across the abdominal cavity, runs obliquely from below upward. At the left end, the transverse colon is held in place by the strong ligamentum gastrocolicum. The acute angle produced at this point by the prolapse of the other end of the transverse colon, causes a partial occlusion of the lumen of the gut (enterostenosis). The transverse colon, therefore, remains contracted and empty, and gives the condition described as "corde transverse." Coincident with the descent of the transverse colon, there is a relaxation of the ligaments (mesenteries) of the small intestines, and this produces a dragging down of the stomach, and causes the liver and kidney, through the liga-

¹ Read before the Fifth District Branch of the N. Y. State Medical Association, May 26, 1896.

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mentum gastro-colicum, to assume a lower position than normal (hepatoptosis and nephroptosis). Thus there may be a prolapse of all the intestines (splanchnoptosis). This enteroptosis causes enterostenosis and increases the specific gravity of the intestines, because they do not contain gas, thus diminishing the abdominal tension. A *ciculus vitiosus* is produced which, if not interfered with, grows worse.

The subjective symptoms of this disease are: Weakness and constant feeling of lassitude; difficulty in digestion of fats, farinaceous foods, acids, pure wine, pure milk, with an increase in the digestive troubles about three hours after meals; sleeplessness; usually constipation or irregularity of the bowels.

The objective symptoms, according to Glénard, are: (1) Splashing sound (*clapotement épigastrique*). (2) Pulsation of the abdominal aorta (*battement aortique*). (3) "Corde colique transverse." (4) In the right hypochondriac region, frequently movable kidney.

By the "corde colique transverse," Glénard means that resistance, which is found lying over the aorta from three to five centimeters above the navel, running horizontally from six to ten centimeters on each side of the median line. This gives the impression of a sausage-like body, one centimeter in width, and was supposed by Glénard to be the displaced colon transversum, for pressure on the right iliac region at the beginning of the colon ascendens produced rumbling sounds in the corde transverse.

Glénard distinguishes three different periods of the disease. During the first period (atonie gastrique par entéroptose) the patient eats everything, but experiences slight somnolence or a burning sensation after meals; about 2 o'clock A.M., the sleep is interrupted for a few minutes. Generally there is one evacuation of the bowels in the morning, of somewhat diarrheic nature; there is a gradual loss of strength. In the second period (mésogastrique, gastrophtose) the patient avoids fat, farinaceous foods, acids, milk, wine; complains of a sensation of dragging, false hunger, and emptiness about three hours after meals. About 2 o'clock A.M., he remains awake for two or three hours; suffers from constipation, interrupted once in a while by diarrheic evacuations; always feels tired, particularly when arising, and about three o'clock in the afternoon. In the third period (neurasthénique, enterostenose) the patient has lost thirty or forty pounds, and is not sufficiently nourished; he has lived on milk diet, on purées, beef-tea—on most improbable meals; complains of a weighty sensation or cramps in the stomach, and is almost constantly suffering. He does not sleep; the constipation is most obstinate; the daily enemata with difficulty effect an evacuation of fatty scybala, surrounded by mucus or pseudo-membranes from time to time. There is constant complaint of great weakness, so that he hardly leaves the room, and lies on the lounge constantly. He represents the most varied nervous symptoms—cerebral, spinal, sympathetic, both psychical and physical.

As this whole series of symptoms is caused and explained (1) by enteroptosis, (2) enterostenosis, (3) deficient nutrition, the fundamental indications for the successful treatment are pointed out by Glénard in the following way: (1) The intestines have to be raised and maintained in their position. (2) The abdominal tension must be increased. (3) The bowels have to be regulated. (4) The secretions of the digestive tract and of the annexed glands have to be stimulated. (5) The alimentation has to be regulated and the digestion assisted. (6) The organism has to be stimulated. The first two points are accomplished by wearing an abdominal bandage reaching to the navel and exerting a pressure upon the hypogastrium from below upward. This bandage raises the intestines and increases the tension of the abdomen.

To regulate the bowels, Glénard gives his patients, a quarter of an hour before breakfast, any one of the following: Natrium sulphate, 4.0, magnesia sulphate, 3.0, in half a glassful of water, or a teaspoonful or half a glass of Janos; one quarter of a glass of Rubinat; a teaspoonful of Carlsbad salt, or pills consisting of 0.05 extractum rhei. The fourth requirement must be accomplished by massage, electricity, and lavage of the stomach; and the sixth, by gymnastic exercises.

Glénard first pointed out that the diet should contain plenty of meats, but not of milk, as was formerly customary; frequent meals should be advised, while the quantity of liquids should be greatly reduced.

As has been shown by Ewald, the best sign to

recognize enteroptosis, is the demonstration of an existing gastroptosis. This can occasionally be recognized by the splashing sound, which can be produced on the left side of the abdomen over an area extending from the navel, or somewhat above it, down to the symphysis. The inflation of air is another means of detecting the position of the stomach; when the stomach is inflated, the lesser curvature, in cases of gastroptosis, is visible midway between the ensiform process and the navel, or just near the umbilicus.

Gastrodiaphany has been recommended by me as a reliable means of recognizing gastroptosis. It makes the stomach visible as a red zone on the abdomen, between the navel and the symphysis.

To recognize the movable kidney it is only necessary to practise palpation, putting one hand on the back of the patient at the lumbar region, while the other is held flat below the margin of the false ribs, covering the lower outside angle of the abdomen. By having the patient inspire deeply, the kidney, if movable, is felt to slip between both hands; slight pressure with the hand on the lumbar region will facilitate the recognition.

While Israel is of the opinion that on a deep inspiration even a normal kidney may be partly felt by this method of examination, Glénard considers all cases in which the kidney can be detected by palpation as abnormal. He distinguishes four degrees of movable kidney: First degree of nephroptosis: the lower part of the kidney can be palpated during deep inspiration; during expiration, the kidney slips back to its

normal place, and it is impossible to prevent its return. Second degree: the greater part of the kidney can be palpated, and it can also be held in its abnormal position, but its superior margin cannot be felt. Third degree: the superior margin of the kidney can be reached on deep inspiration. Fourth degree: the whole kidney is accessible to palpation, even during expiration (the movable or wandering kidney of the older writers). Movable kidney is, according to Glénard, only one of the symptoms of enteroptosis.

It is generally accepted that the corset plays a predominant part in the causation of the downward displacement of the abdominal organs; confinement is also believed to be a great factor. But besides these two points, which refer only to the female sex, there are some other conditions which, likewise, predispose to enteroptosis and are common to both sexes, namely, acute diseases of a grave nature, and protracted ailments accompanied by a considerable loss of flesh.

In January, 1896, I saw 57 male patients with gastric disturbances; among them were 4 with a distinct enteroptosis and right movable kidney (third and fourth degrees); the number of females with the same disturbances amounted to 33, and 13 had distinct enteroptosis with a right movable kidney. April showed similar figures: Number of male patients, 84; enteroptosis with movable kidney, 5; number of females, 59; enteroptosis with movable kidney, 19.

Among the male patients with digestive disorders, the percentage of enteroptosis was 6.2,

while in the females with the same kinds of affections, the percentage was 34.8. The great frequency of enteroptosis, which has been stated by Glénard, is fully sustained by the figures just given. Glénard, however, goes too far when he ascribes all digestive disturbances to this faulty position of the abdominal viscera, nor is enteroptosis always the only cause of all the symptoms. According to my own experience, pronounced enteroptosis may exist without any manifestations of morbid phenomena. It is also self-evident that all kinds of gastric affections will occur in cases of enteroptosis as well as elsewhere; for enteroptosis does not afford immunity against digestive disorders. Hence it appears that, aside from the diagnosis of enteroptosis, it is often necessary to recognize the existence of other factors. I must, however, concur with Glénard that in many instances enteroptosis, as such, is liable to produce symptoms, and that these symptoms can be materially improved by the treatment outlined above. The abdominal bandage (which should raise the abdominal viscera) and the restriction of liquids seem to be the most important measures, and should be applied in all cases of this affection.

Meinert¹ examined a large number of young chlorotic girls with regard to the position of the stomach, and found the greater curvature always occupying a very low position (between the navel and symphysis); he concluded that "the gastrophtosis" in his cases was the cause of the existing chlorosis. The method which he used

¹ E. Meinert, "Zur Aetologie der Chlorose," Wiesbaden, 1894.

to determine the position of the stomach was that of Frerichs; it consists of giving the patient bicarbonate of soda and tartaric acid in two separate portions of water, taken in succession. The carbonic acid gas collecting in the stomach, inflates this organ. The position of the stomach then may be recognized by mere inspection or by percussion. Instead of administering two grams of each of these drugs as is ordinarily done, Meinert gave eight grams. The results this writer obtained do not represent the stomach in its natural state, but in an artificially overdistended condition. Leo¹ and Meltzing,² the latter using the gastrodiaphane, refuted Meinert's statement. There is no doubt that Meinert's method of ascertaining the position and size of the stomach is not a very good one, and apt to misrepresent the true condition. Although the occurrence of enteroptosis in chlorosis is quite frequent, Meinert's statement that gastroptosis is a prime factor of chlorosis is not sufficiently proven. Chlorosis is not infrequently met with in persons not affected with enteroptosis, nor are all the patients with enteroptosis chlorotic. The corset, upon which a great deal of blame has justly been put for the causation of the descent of the abdominal viscera, and which, according to Meinert, is a great factor in the production of chlorosis, cannot be recognized as a useful and hygienic garment, and ladies wearing it should, at least, be careful not to lace too tight.

¹ H. Leo, "Ueber Gastroptose und Chlorose," *Deut. med. Woch.*, 1896, No. 12.

² Meltzing, "Gastroptose und Chlorose," *Wiener med. Presse*, 1895, No. 30-34.

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